



California's HMO Enrollees: Diversity in Language and Education Poses Challenges for Health Plans

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California's health maintenance organizations (HMOs) face serious challenges in meeting the needs of their members who have diverse language proficiency and educational attainment. This policy brief summarizes findings from a report that is the most comprehensive profile of the state's entire HMO membership available to date, including commercial, Medicare, Medi-Cal, and Healthy Families members. Also included are an assessment of the readability of HMO member materials and the availability of linguistic services for limited English-proficiency members, who represent almost 5% of HMO members statewide (see Exhibit 1).

More than one-third (35%) of California's nonelderly HMO members have a high school education or less (see Exhibit 2)—yet, the vast majority (94%) of the material describing their benefits is written at the college or graduate school level (see Exhibit 3) and presented in a format that may be difficult for most consumers to use. In addition, although 34% of the state's HMO population communicates at home in a language other than English, not all HMO plans ensure the same linguistic services to all of their limited English-proficiency members.

continued on page 3

Language Proficiency and Educational Attainment of HMO Members Statewide

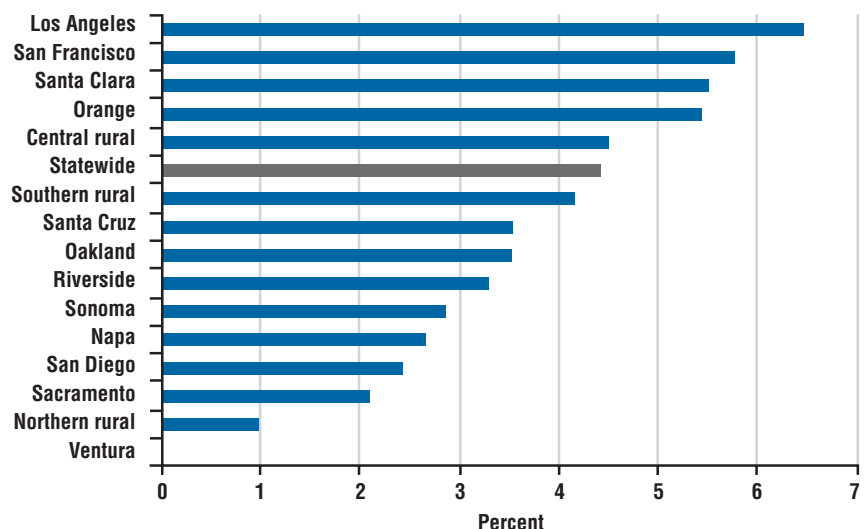
HMO plans strive to ensure the best possible access to health care for California's HMO enrollees. Access to important health services such as cancer screenings and treatment for chronic conditions is determined not only by whether these services are covered by a health plan, but by the extent to which the plan assists its diverse membership in understanding these and other benefits. As shown in Exhibits 1 and 2, California's HMOs face serious challenges in meeting the needs of their membership because of limited English proficiency and levels of education.

This policy brief covers:

- *Comprehensive Profile of State's HMO Membership*
- *Readability of HMO Member Materials*
- *Availability of Linguistic Services*
- *Policy Recommendations*

Exhibit 1:
Percentage of HMO Members with Limited English Proficiency. All Ages, by Region.

Source: 2001 California Health Interview Survey

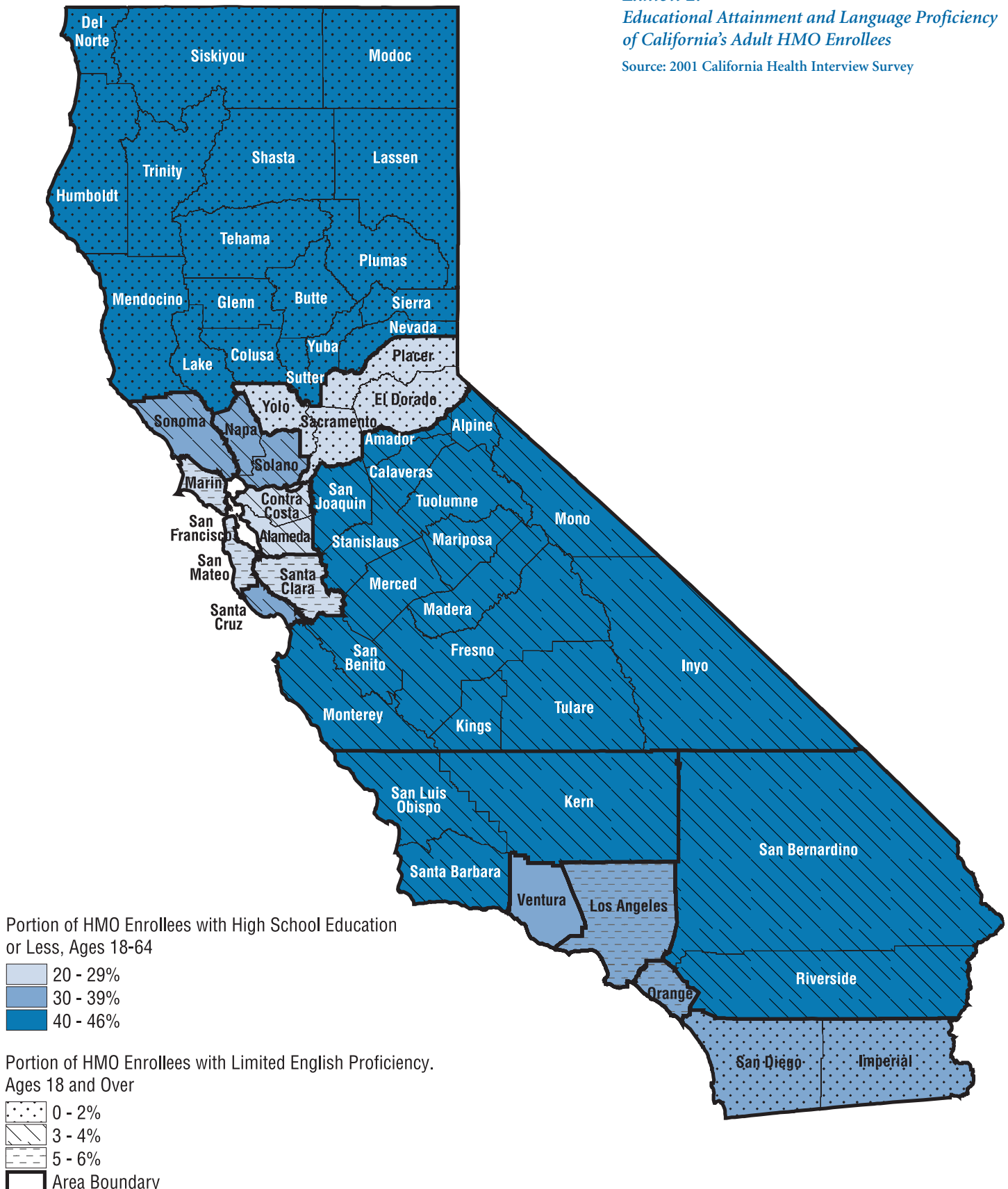


Note: Limited language proficiency is defined as HMO members who report that they speak English "not well" or "not at all." Ventura County has too few observations to report.



Exhibit 2:
Educational Attainment and Language Proficiency
of California's Adult HMO Enrollees

Source: 2001 California Health Interview Survey



Note: Ventura County has too few observations to report on language proficiency.

HMO Member Profile Paints a Diverse Picture

More than half (54%) of California's population is enrolled in an HMO—approximately 17.7 million children and adults in 5.5 million households.¹ This HMO population is extremely diverse. Six in 10 enrollees (59%) are white, two in 10 (19%) are Latino, 12% are Asian American and Pacific Islander, 7% are African American, and 3% comprise several smaller racial groups, including American Indians and Alaska Natives.

More than one-fourth (27%) are immigrants; 15% are naturalized citizens and 12% are noncitizens. Twelve percent of HMO enrollees were not born in the United States but have lived in this country for 20 or more years; approximately 3% are new immigrants (having lived in the U.S. less than five years).

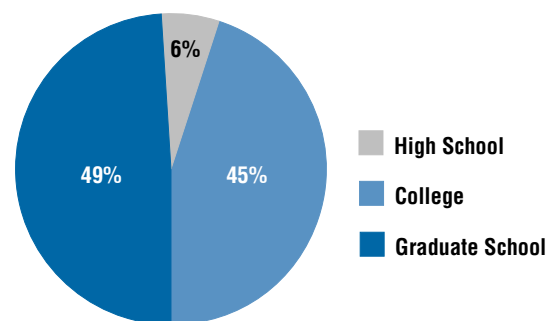
Because so many people in California have immigrated from other countries, effective communication is an important concern for the state's health-care providers. One in three (34%) HMO members in California speaks a language other than English at home (24% are bilingual and 10% speak solely another language). A total of 4% of HMO enrollees statewide report limited English proficiency (see Exhibit 1). In Los Angeles and Santa Clara counties, nearly half of the population communicates at home in a language other than, or in addition to, English.

One in three (35%) HMO members ages 18-64 and almost half (45%) of enrollees ages 65 and over have no education beyond high school. Among 18-64 year olds, the proportion with a high school education or less ranges from 20% in the San Francisco area to 46% in the Central Rural region (see Exhibit 2).

Materials Not Readable to Many

HMOs regularly send their members handbooks, flyers, newsletters, and brochures intended to educate them about their plan coverage, benefits, rights, and type and location of available services. However, these materials are often written at a level not easily understood by most members.

Ninety-four percent of HMO consumer-education materials are written at the college or graduate school level, while only 6% were written at the high school level (see Exhibit 3).



Among the general public, half of all adults read at an eighth-grade level or lower, while among adult HMO enrollees, 37% have a high school education or less. Thus, there is a mismatch between the reading level required to understand the information communicated and the literacy levels of a large portion of the target audience.

Systematic content analysis of these written materials from the eleven largest HMOs in California showed a number of factors that contribute to high readability levels. There was excessive use of polysyllabic words, lengthy sentences, and complex paragraphs with obscure grammatical constructions, as well as difficult-to-read font sizes and types. Only half (51%) have either introductory or summary statements for sections of text. Just one in seven (14%) has clear pronoun references and only 3% highlight new words. One in six (17%) provides definitions or synonyms for key terms

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Exhibit 3:
Reading Level of HMO Materials

Source: Health and Media Research Group (HMRG), UCLA School of Public Health, 2002.

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¹ According to reports filed by health plans with the state Department of Managed Health Care, there are over 20 million health plan members in the state. However, this figure includes membership in two large PPOs and double counts individuals who are members of plans that subcontract with other plans. When these are factored out, the number of health plan members reported to the state is similar to the number derived from the 2001 California Health Interview Survey.

that are not widely understood, and slightly more than half (55%) have relevant illustrations. Therefore, many of these materials are difficult to read, especially for the less-educated consumer.

While HMOs have put some thought and effort into making their documents more user-friendly, such efforts are often hampered by a lack of coordination among multiple contributors and by use of overly sophisticated language that conforms to legal or accreditation standards.

Linguistic Services May Vary Depending on Coverage Type

The diversity of California's HMO membership increases the importance of providing linguistic services for members with limited English proficiency (LEP). These services include telephone and face-to-face interpreters and written materials translated into other languages. Health plans also collect member language information and monitor language-barrier grievances. Such efforts play a role in ensuring that LEP members receive the same quality health care as non-LEP members.

Although many health plans provide appropriate linguistic services for their members, there is variability in how members are informed about available services as well as how to access services. Additionally, the linguistic services offered may vary based on the member's type of coverage.²

Many HMOs provide certain interpreter and translation services for their Medi-Cal, Medicare, and Healthy Families members to meet federal and state contract requirements, but do not routinely offer the same services to their commercial members, who are not covered by these requirements.

Across all types of coverage (commercial, Medi-Cal, Healthy Families, Medicare), 90% of plans report that they ask some members to indicate their preferred language at the time they enroll. But only 30% ensure that a member's primary language is documented in

his or her medical records; 70% shift that responsibility to the delegated medical group, independent practice association (IPA), or individual provider.

When asked, HMOs report that they track "predominant" languages of their members, where *predominant* is defined as *at least 3% of the member base of the health plan*. All HMOs participating in the Medi-Cal and Healthy Families programs report that Spanish is a predominant non-English language of members. Spanish is also a predominant non-English language in approximately 83% of HMOs with commercial coverage and 90% with Medicare coverage. Chinese is predominant in approximately 40% of plans with Medi-Cal and Healthy Families coverage, 25% of plans with commercial coverage, and 33% of plans with Medicare coverage.

Across all types of coverage, 85% of plans report that they have a procedure in place to monitor their non-English speaking member population and to adjust or target provider contracting accordingly.

All plans report that they provide telephone interpreter services for LEP members at no cost and have bilingual staff members who speak a language other than English. Eighty-five percent of plans report that they contract for language line services.³ Eighty percent of plans report that they provide telephone interpreters at medical points of contact for at least one line of business. Similarly, 80% offer access to face-to-face interpreters for some LEP members at medical points of contact. Ninety percent of plans that offer face-to-face interpreter services do so at no cost to the member.

Across all types of coverage, only 65% of plans report that they directly arrange and pay for telephone or face-to-face interpreter services for at least one line of business. Another 30% delegate this responsibility to their contracted medical group or provider, and 5% report that they provide access information to commercial HMO enrollees, who are then responsible for

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2 HMOs may offer several types of coverage, known as *lines of business*, including commercial, Medicare, Medi-Cal, or Healthy Families, based on the source of payment.

3 Language line services are provided by a company of telephone interpreters contracted by a health plan to speak with members when an appropriate bilingual staff member is not available.

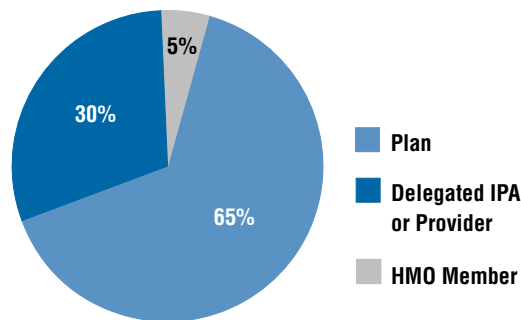
arranging their own telephone interpreter services (see Exhibit 4).

Twenty percent of HMOs across all lines of business report that they use a standardized measure to evaluate the language proficiency of their health-care providers. Approximately 60% report that information on provider language proficiency is self-reported by the provider, while a smaller proportion of HMOs report having no such evaluation process in place. Regarding member service staffs, 85% of HMOs report that they evaluate bilingual language proficiency while 10% conduct such staff assessment via self-report, and 5% report having no such evaluation process.

Policy Recommendations

California continues to be at the forefront of the HMO field, as evidenced by the establishment of the California Office of the Patient Advocate (OPA), which distinguishes California as the first state with an office dedicated to assisting HMO members to attain the highest quality of care and services. California also has the nation's most diverse population, adding to the challenge OPA and individual health plans face in ensuring that this goal is met. The ability of HMO enrollees to understand membership benefit materials provided by their plans and to access linguistic services when needed are essential for increasing HMO public accountability and assuring that HMOs are responsive to member needs.

The comprehensive demographic profile of California's entire HMO population summarized in this Policy Brief suggests that effective HMO outreach and communication requires recognition of the diversity in ethnicity, English proficiency, and educational attainment of the membership. The ethnic diversity, variety of languages spoken, and varied literacy levels among California's HMO population point to potential barriers for HMO members in understanding their plan's policies and programs and obtaining access to



services. Thus, when preparing materials for distribution and outreach, HMOs need to provide information in different languages that are adapted for the cultural variations in their member populations.

Because the educational attainment of HMO enrollees varies within the state, the Office of the Patient Advocate has an opportunity to establish guidelines for the development of materials written by HMOs so that respective policies and benefits are clearly communicated to all enrollees, particularly those with high school educations or less. OPA and individual health plans also need to recognize the diversity of California's HMO membership in their efforts to educate enrollees regarding their health-care benefits, rights, and needs.

The discrepancy between the educational attainment of HMO enrollees and the readability level of the materials designed to educate them about their benefits—compounded by the fact that these materials are often presented in ways that are confusing even to highly educated members—is cause for serious concern. When consumers receive difficult-to-understand materials, they are likely to put them aside without reading them. While HMOs may be motivated to produce more readable documents, they have clearly not always been successful. OPA can take an active role in supporting efforts to improve the readability of member materials.

Exhibit 4: Who Is Responsible for Providing Interpreter Services?

Source: California Office of the Patient Advocate, 2002.

A strong benefits package may be of little use to members who have trouble understanding what those benefits actually are and how to gain access to them...

The use of overly complex language should be examined and recommendations made for the translation of these materials into text that is easy to understand. HMOs should also be encouraged to improve coordination in the development of these materials. More critically, **the Office of the Patient Advocate needs to establish a service to provide technical assistance to HMOs in testing for readability and in revising materials accordingly.**

Clearly, obtaining high quality care and services depends greatly on the ability of an HMO member to communicate with his or her health-care provider and health plan representative. HMOs should be responsible for assessing their members' language needs and tailoring services to meet those needs. This involves not only collecting member-language information, but also providing appropriate linguistic services at medical points of contact. It also means offering the same linguistic services to all members, regardless of type of coverage.

Many HMOs are providing certain interpreter and translation services for their Medi-Cal, Medicare, and Healthy Families members to meet federal and state requirements, but they are not consistently offering the same services to their commercial members who are not covered by these requirements. Such distinctions create confusion and may unnecessarily limit access to entitled benefits among commercial LEP members. **All health plans need to adopt standardized procedures to inform LEP members about the availability of interpreter and translation services as well as how to obtain them.**

In the past decade, a number of performance-reporting measures have been implemented to improve the ability of HMO consumers to assess the quality of services provided by plans, including those reported by the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans (CAHPS). These

measures, however, may not capture all the dimensions of health plan performance that affect a diverse population. A strong benefits package may be of little use to members who have trouble understanding what those benefits actually are and how to gain access to them, or if the benefits are not explained in the member's language of choice.

Data Sources

This Policy Brief reports the findings of three separate studies, two conducted by the UCLA Center for Health Policy Research under contract with the California Office of the Patient Advocate (OPA), and the third conducted by OPA staff.

The first study was headed by Gerald Kominski and has been published as a separate UCLA Center for Health Policy Research report (January 2003).⁴ That study analyzed information describing the demographic profile of California's HMO enrollee population using data from the 2001 California Health Interview Survey (CHIS), the largest state health survey conducted in the United States. The demographic profile was developed using the random-digit dial (RDD) telephone sample from CHIS 2001, which collected information from 55,428 households (55,428 adults, 5,801 adolescents ages 12-17, and 12,592 parents about a child in their home ages 0-11). For full information on the data and methods used to develop the demographic profile, see Kominski et al., referenced below, p. 53. Additional information regarding CHIS 2001 is available at www.chis.ucla.edu.

The second UCLA Center for Health Policy Research study was headed by Deborah Glik and assessed the readability of consumer education materials provided by eleven of California's largest HMOs by applying two well-known readability scoring tools: the Simple Measure of Gobbledegook (SMOG) test, which assigns a grade level of difficulty to written material based on the number of polysyllabic words and the length of sentences; and the Readability Assessment Instrument, which looks at grammatical and organizational characteristics of written material, including the logical structure of the document, the coherence in meaning from one sentence to the next, the adequacy of definitions, and

4 GF Kominski, PL Davidson, CL Keeler, N Razack, LM Becerra, R Sen, *Profile of California's HMO Enrollees: Findings from the 2001 California Health Interview Survey*. A Report for the California Office of the Patient Advocate. Los Angeles: UCLA Center for Health Policy Research, January 2003. For copies of this report, visit www.healthpolicy.ucla.edu.

the general appearance of the materials presented (presence and relevance of illustrations and font size and type), among other measures. This approach considers the fact that longer, more complex paragraphs with obscure grammatical constructions are hard to understand, especially for persons with lower levels of literacy.

The data on linguistic services in California HMOs is a summary of information from a survey developed by the Office of the Patient Advocate with assistance and input from the ad hoc OPA Cultural and Linguistic Services Work Group. The survey was mailed to health plan CEOs and sent as an electronic document to key contacts in 20 HMOs in May 2002. Nine commercial HMOs (consisting of more than 95% of commercial enrollees in the state) and eleven county-based local-initiative health plans and their plan partners participating in the Medi-Cal program received the survey. The information is based on voluntary self-reports. The survey and more detailed information are available from the OPA in a comprehensive report.⁵ OPA also provides a summary of the linguistic services information for consumers on the 2002 HMO Report Card, available at www.opa.ca.gov.



california
health
interview
survey

The California Health Interview Survey (CHIS) is a collaboration of the UCLA Center for Health

Policy Research, the California Department of Health Services, and the Public Health Institute. Funding for CHIS 2001 was provided by the California Department of Health Services, The California Endowment, the National Cancer Institute, the California Children and Families Commission, the Centers for Disease Control and Prevention (CDC), and the Indian Health Service. For more information on CHIS, visit www.chis.ucla.edu.

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5 State of California, Office of the Patient Advocate, *HMO Services in Other Languages: A Portrait of California Health Plans and Linguistic Services for Limited English Proficient Members*, April 2003. For copies, contact OPA at 1-866-HMO-8900.

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